Toronto Central **LHIN**

Partnership in Action: Building a Local Health System for All

Annual Report 2012/13

Ontario

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Letter from the Board Chair and CEO

We are very pleased to provide the Toronto Central (TC) LHIN 2012/13 Annual Report.

Last year the TC LHIN released its Strategic Plan or 2013-2016 Integrated Health Service Plan (IHSP-3). This is our LHIN's course of action to achieve a more person-centred and high-quality local health system.

This plan reflects the ideas of people whom we have consulted: patients and community groups; health service provider executives and Boards; health professionals; partner organizations; and representatives from the Ontario government and City of Toronto.

The IHSP-3 can be distilled into a single phrase: *Transforming the system for your health.* We all recognize that the health system needs to fundamentally change. This will require us to have a long-term view, while taking immediate actions to address the most pressing health care issues. Our ultimate goal is to improve people's lives by providing them with the best possible health care.

The Annual Report shows that the changes that are underway in our LHIN are making a positive difference to people who use local health care services.

For example, with advice from over 250 people, including primary care physicians and patients, we created the first-ever review and plan for enhancing primary care in our region.

The TC LHIN's Primary Care Physician Advisors worked with their peers to find ways to connect people without primary care to family physicians in the LHIN. These efforts are paying off. There has been a 10 percent increase in the number of TC LHIN residents connected to a family physician through the Health Care Connects program since October 2012. For vulnerable patients, the "attachment" rate has gone up 17 percent!

This is an excellent start but there is much more to do. Many TC LHIN residents are still without a regular family doctor and others cannot get an appointment when they need medical attention.

The solution is to better coordinate everyday health services within communities, close to where people live. And people need easy and dependable referrals for specialized services across the city. Boundaries should be invisible and patients should not encounter obstacles to the services they need.

Angela Ferrante
Board Chair

Camille Orridge
CEO

Health Links are a key strategy for achieving this goal. For the first time, providers within a local area will be collectively accountable for improving the outcomes of the people who live in their area. The TC LHIN is very excited about the potential for Health Links. Within six short months, we have developed a TC LHIN-wide plan for nine Health Links.

The first four have been formed and already have initiatives in play to better support complex patients in their areas.

Another key focus is building capacity within the community sectors to enable people with complex needs live with greater independence close to home.

The TC LHIN invested over $22 M in community health services last year for new and enhanced services for frail older adults, people with mental illness and addictions, Aboriginal women and youth and others in need.

As part of our system-wide effort to improve health quality, the TC LHIN began work to systematically measure the patient experience across the continuum of care.

While patient experience measurement is critical, it doesn't tell the whole story. This year the TC LHIN received direct feedback from people who face barriers because of language, poverty, social isolation and other factors. This included in-depth engagement of people living in St. James Town and Mount Dennis, two diverse and densely populated communities that are home to many newcomers.

These discussions underscore that we must do more to improve the quality of health care in the city. Many people find the system to be frustrating and difficult to understand and navigate. Too many people are not receiving the services they need.

Our conversations with community members remind us that good health is about much more than health care and that, ultimately, it will take partnerships with social services, education, housing, transportation and other sectors to create a healthier city.

The Board of Directors and the TC LHIN staff look forward to continuing to work with our partners within health care and across the city to build a great local health system for everyone.

Angela Ferrante
Board Chair

Camille Orridge
CEO

Toronto Central LHIN Population Profile

TC LHIN Population Facts

- 2.6 million people live in Toronto, the fifth largest city in North America and 1.15 million people live within the TC LHIN.
- 2.4 million daily commuters come into Toronto.
- 54% of patients in TC LHIN hospitals and 55% of patients who see family physicians in the TC LHIN reside in other LHINs.
- An estimated 32% of the population is 22 to 44 years old and 14% is aged 65 years and older. Seniors will account for 14.8% of the LHIN's population by 2016.
- In TC LHIN 41% of residents are immigrants, 8.3% of whom arrived in Canada between 2001 and 2006.
- 170 languages and dialects are spoken in Toronto and 4.5% of the population reports no knowledge of either official language.
- There are 53,000 Francophones in Toronto (9.2% of Ontario's Francophone population and 2.2% of TC LHIN's overall population). Many are recent immigrants and/or visible minorities.
- There are 19,265 people of Aboriginal Identity in Toronto. Toronto has one of the largest Aboriginal populations in Canada. Aboriginal people in the city tend to have poorer health at a younger age than the general population.

- Just over one quarter of the population is low income, the highest rate of all the LHINs and approximately 5,000 people are homeless in the City of Toronto.
- Toronto has the highest number of lesbian, gay, bisexual and transgender (LGBT) people in Canada.
- 5% of people who use health care services, or approximately 22,500 people in the TC LHIN use over 50% of the hospital and Community Care Access Centre (CCAC) resources and they are known as "complex clients" which include frail elderly, adults with multiple chronic conditions, medically complex children and palliative clients.

What do we mean by "complex clients or patients?"

- Includes frail seniors, adults with multiple chronic conditions, medically complex children and palliative clients.
- A high proportion are over the age of 65, the highest concentration of whom are over the age of 80.
- They have two or more chronic conditions, take multiple medications and see multiple providers.
- They tend to visit the emergency room (ER) or need to be hospitalized more than the rest of the population.
- Many with physical and/or cognitive health issues need assistance with day-to-day living including dressing, going up stairs and making meals.
- People with complex mental illness and addictions tend to be younger (20-64).
- They tend to have physical conditions such as diabetes, cancer and HIV/AIDs.
- Certain groups are more likely to have complex mental illness and addictions and have difficulty connecting to appropriate care including Aboriginal people, low income earners, and newcomers to Canada.

An Aging Population

Compared to the rest of the province, a higher proportion of young adults live in the TC LHIN. Thirty-two percent of people in the TC LHIN are between the ages of 22 and 44.

Seniors aged 65 years and older accounted for 14 percent of the population in 2011. People aged 75 to 84 accounted for five percent of the population. Between 2016 and 2031, this group is projected to make up 45 percent of the population.

Today's seniors are living longer and healthier which brings tremendous social and economic benefits. At the same time, health care use rises as people age and most costs are incurred during people's final years of life. With the large cohort of aging baby boomers reaching their senior years, health care costs will inevitably continue to grow. Our challenge is to manage the rate at which those costs grow by improving the quality of care and investing in services that add value.

Who Receives Care in the TC LHIN?

In addition to the people who live in the TC LHIN area, providers also serve people from across the GTA and Ontario. Our health care system plays a local role as well as a regional and provincial one. About half of the people receiving care in our region come from other LHINs. A number of hospitals in the TC LHIN provide specialized services not offered anywhere else in Ontario. Also, some 2.4 million daily commuters come into Toronto each day, some of whom receive primary and other services in the TC LHIN.

Currently 54 percent of patients in TC LHIN hospitals and 55 percent of people who receive primary care in the TC LHIN reside in other LHINs.

Aboriginal Peoples

According to the 2011 Census, there are 31,390 people of Aboriginal origin in the City of Toronto. However, Aboriginal service providers estimate that the number could be higher, upwards of 70,000, due to the challenges of reaching out to this population.

Toronto's highly diverse Aboriginal community is made up of many different First Nations peoples from across the country as well as Inuit and Métis.

Aboriginal communities have significant health disparities and have been historically marginalized within the mainstream system. Aboriginal people in the city are, on the whole, in poorer health than the general population. For example, diabetes in the Aboriginal communities is three to five times higher.

There is, however, limited reliable information about the health status and health care use of Aboriginal peoples due to the fact that Aboriginal ethnicity is not flagged in health administrative data sets, such as those that analyzed by the Institute for Clinical Evaluative Sciences (ICES).

Francophones

Toronto has a substantial Francophone population of 53,000 (9.2 percent of Ontario's Francophone population), many of whom are recent immigrants and/or visible minorities.

Francophones are increasingly diverse, with 49.8 percent born outside of Canada and a high proportion of recent immigrants, largely from African countries. Francophones are dispersed across the city and do not tend to live in any particular neighbourhoods. Likewise, French language health services are scattered across the TC LHIN which contributes to challenges navigating the health care system.

Immigrants

In the TC LHIN, 41 percent of residents are immigrants, 8.3 percent of whom arrived in Canada between 2001 and 2006.

Some 170 languages and dialects are spoken in Toronto. While they contribute to the city's rich diversity, newcomers face barriers to care, particularly if they don't speak English. Today, 4.5 percent of the population reports no knowledge of either official language.

Evidence shows that people with limited proficiency in English stay longer in hospital when they are unable to communicate in their first language. Conversely, the quality of care increases when a patient is able to communicate in their own language.

Refugees

In 2011, there were 26,362 refugees in the TC LHIN. The majority came from Europe/United Kingdom (29.5%), followed by South and Central America (23%), then Africa (22.6%). The top five countries of origin are Hungary, China, Columbia, Pakistan and Namibia.

There is widespread concern that the federal government's change to the Interim Federal Health (IFHP) Program, a program that provides temporary health benefits to refugees, is very harmful to an already vulnerable group.

Health of the Population

Two-thirds of TC LHIN residents say they have very good or excellent health; the highest proportion in the province. Although this proportion decreases with age, the rate is relatively high even among seniors with 44 percent rating their health as very good or excellent. Three out of four residents report very good or excellent mental health.

A total of 89 percent of TC LHIN residents report having a regular medical doctor. This is lower than most other LHINs.

In terms of lifestyle, approximately 18 percent of TC LHIN residents are smokers and 17 percent are heavy drinkers. The rate of obesity among adults is the lowest in the province (38%), however it is concerning that half of the people living in the TC LHIN are physically inactive.

Mental Health and Addictions

According to the TC LHIN Service Capacity Overview Project (SCOP Study) it is estimated that 23.8 percent of the adult population in TC LHIN lives with a mental disorder (not including addictions). The prevalence for the Ontario adult population is estimated at 16.7 percent.

Of the total TC LHIN adult population, it is estimated that there are 23,975 individuals living with a serious mental disorder marked by considerable clinical, functional and behavioural issues requiring ongoing specialist treatment and supports.

An estimated two to three percent of the TC LHIN adult population is estimated to have alcohol dependence.

32.6% of TC LHIN residents over the age of 12 have chronic conditions:

- Asthma 8%
- Diabetes 5.9%
- Heart disease 4.3%
- High blood pressure 14.1%
- Chronic obstructive pulmonary disease (over the age of 35) 2.8%

At 25,948 visits, the TC LHIN has the third highest rate of mental health/substance abuse visits to the Emergency Department (ED). The average length of stay for mental health/substance abuse patients is 37.4 days, with a 30-day readmission rate of 13.3 percent. The largest proportion of these active cases in TC LHIN hospitals is attributed to schizophrenia, psychotic disorders and mood disorders. Compared to the provincial average, TC LHIN has a lower rate of active cases for ages 15-19 years, however it has a high rate for all other age groups.

Health Inequities

- A report by the Centre for Inner City Health (CRICH) and ICES suggests that those in lower income groups are exposed to greater health risk, have more complex health conditions and tend to use the local ED for mental health services and are most likely to also go to the hospital for non-emergencies. On the other hand, higher income patients tend to be healthier, live longer and have fewer chronic diseases.
- According to the 2006 Aboriginal Peoples Survey, over half of First Nations (58%) and Métis (55%) adults living in Toronto reported that they had been diagnosed with at least one chronic condition. Diabetes in the Aboriginal communities is three to five times higher.
- Higher needs neighbourhoods also tend to have higher rates of diabetes than more affluent areas.

The 5% Most Complex People

We have identified approximately 22,525 people who are high users of hospital and CCAC services. They are commonly known as the 5% of the population who use the most health care resources and have the most complex care needs.

Proper intervention and appropriate support at the right time and right place makes a difference to their outcomes and quality of life. Better management of these patients also reduces costs that can be reinvested back into the health care system. Populations in the 5% group include people with serious mental illness and addictions, palliative care clients, frail seniors, adults with multiple chronic conditions and medically complex children.

Engaging the Toronto Central LHIN Community

While improving health outcomes is obviously important to everyone, another part of high quality care that we are paying close attention to is people's experience in the health care system.

Knocking down some of the barriers to accessing care involves speaking to members of the community first-hand about their experiences in the health care system and considering their perspectives when we plan health services and investments. Over the last year, the TC LHIN has led or participated in a number of projects that are giving patients a greater voice in health care change.

The TC LHIN plays various roles in patient/client engagement. Some of these activities are part of specific TC LHIN-led projects, such as improving health services in different neighbourhoods and addressing gaps in areas including mental health and addictions, seniors care, assisted living and Aboriginal health. The TC LHIN requires that all funded projects, health system integrations and capital projects are to be informed by patient and client engagement as well as consultations with other affected stakeholders.

The TC LHIN seeks out the voices of those who use health care services in order to help set priorities, identify problems and pinpoint what needs to be done to improve health care experiences, outcomes and the lives of patients/clients and their caregivers. The following are some of the highlights from the last year.

Aboriginal Peoples

The TC LHIN has a number of interrelated initiatives in partnership with Aboriginal community groups, aimed at improving health outcomes and experiences of both the urban Aboriginal peoples who live in the TC LHIN and individuals from First Nations, Inuit and Métis communities who come here for care.

→ Partnership with Ontario Federation of Indian Friendship Centres

This year, we have fostered crucial partnerships to advance culturally competent care for Aboriginal people. The Ontario Federation of Indian Friendship Centres (OFIFC), a provincial Aboriginal organization representing the collective interests of 29-member Friendship Centres located in towns and cities throughout the province, has become a TC LHIN health service provider. This year we funded OFIFC for three Aboriginal mental health and addictions projects designed to address barriers to appropriate and culturally competent mental health care, as well as a cultural competency training program specially designed for employees of provider organizations.

→ Cultural Competency Training

The OFIFC-led Aboriginal Cultural Competency Training has trained staff and executive directors from 60 local mental health and addictions agencies. In 2013/14, the TC LHIN will invest in Aboriginal cultural competency training for staff and executive directors of community

support services agencies. The long-term goal is to embed capacity in provider organizations – from the front-lines to the executive team – to deliver culturally competent care to Aboriginal people.

Culturally aware and respectful care has been identified by Aboriginal people in the TC LHIN as an integral part of quality health care. Some members of the community delay or avoid seeking care when they are ill because of bad experiences, and instead try to look for culture-based services.

New Services for Aboriginal Youth Experiencing Mental Illness and Addictions

Aboriginal youth aged 16 to 24 have significantly higher rates of mental illness and addictions than the general population.

To help address this challenge, the TC LHIN engaged Toronto youth to design and launch two new services geared to the specific needs of "transitional aged" Aboriginal youth moving into adulthood.

Eshkiniigjik Naanwechigegamig, translated from Ojibway means "A Place for Healing our Youth." The drop-in program provides mental health and addictions case management and referral and assessment service within the traditional Aboriginal cultural matrix of healing. The TC LHIN partnered with the Native Canadian Centre of Toronto, Madison Community Services, Central Toronto Community Health Centre and Noojimawin Health Authority on this project.

The second new program called, "Serving Aboriginal Transitional-Aged Youth with Mental Health and Addictions Issues: a Cross-Sectoral Community Model", is a new community support team comprised of two full-time community support case managers based at Native Child and Family Services who provide culturally-based traditional counseling and other supports. This partnership also involves LOFT Community Services, the Centre for Addiction and Mental Health and a range of other organizations with extensive experience serving transitional-aged youth with mental health and addictions issues.

Three engagement sessions were held with Aboriginal youth aged 16 to 24 experiencing mental illness and addictions to inform them of these new services.

The sessions were led by Aboriginal youth mentors and supported by Anishnawbe Health Toronto. Here is what the Aboriginal youth said works in the health care system:

- Services based in language, tradition and culture.
- Programs that foster resiliency, self-worth and self-identity.
- Aboriginal youth/ peer led initiatives – youth leading youth.
- Harm reduction approaches.
- Support Circles, Talking Circles for families, parents and caregivers of youth experiencing mental health and addictions issues.
- Programs that allow artistic expression.
- Programs that offer support and incentives – in order to attend programs, many Aboriginal youth require support like transportation, food and childcare.
- More collaboration – youth, parents and caregivers stated it would be helpful if they had better access to information about where programs for youth are happening.
- Opportunities for workers to build knowledge and deal with vicarious trauma.

Aboriginal Services for Women at YWCA building

Last year we recognized a service gap for Aboriginal women living in Aboriginal units at YWCA's affordable housing complex on Elm Street. Working with the YWCA and mental health and addictions agencies and in consultation with Aboriginal tenants, the TC LHIN invested in ongoing supports for Aboriginal women living in the building.

Francophone Community

Over the last year, TC LHIN focused on a number of areas to improve Francophones' access to culturally competent French Language Services (FLS).

→ Improve Data for French Language Services Planning

The TC LHIN is working with Reflet Salvéo, the French Language Health Services Planning Entity for Toronto Central, Mississauga Halton and Central West LHINs to conduct a community needs assessment, as well as a map of health services available in French in the three LHINs. At the same time, the TC LHIN initiated a survey of all its health service providers to gain a better understanding of the availability of services in French. This is giving us a comprehensive and up-to-date picture of FLS services and opportunities to expand French language capacity in the local health care system.

→ Improve the Capacity of Providers to Deliver FLS

Over the last year, TC LHIN worked with health service providers to complete their inaugural French Language Services Plan. These annual plans will set out how each organization will work to continually offer FLS to Francophones they serve. The TC LHIN has a core group comprised of senior staff responsible for FLS in their organizations that support knowledge transfer. The TC LHIN held well attended webinars and meetings and created reference materials to help health service providers in the process. A number of hospitals are developing collaborative FLS improvement plans to enhance the impact and reduce duplication. The final plans will be completed by summer 2013 and providers will report on their progress in June 2014.

→ Including the Francophone Voice in Service Planning

In addition to several advisory reports from Reflet Salvéo on services for Francophones with mental illness and addictions and HIV/AIDS, Francophones were consulted in the development of TC LHIN's Strategic Plan and IHSP-3; Health Access St. James Town and Mount Dennis Engagement projects; and the Community Investment and Primary Care Think Tanks.

Engaging Diverse Communities and Including All Voices

Typically, engagement with users of the health care system are designed for clients who have the time to participate, can speak English or French, are literate, are mobile and have access to transportation.

These processes tend to be based on uniformity and consistency and are not responsive to variability and diversity. They are also apt to reflect the perspectives of groups who are educated, relatively socially and economically advantaged, conform to Canadian social and cultural norms and speak the same language.

As a result, public engagement often misses the perspectives of the very people the services are intended to help. Services can be designed based on wrong assumptions about people's needs and preferences.

The TC LHIN acknowledges that voices are not being heard and identifies what we do not know about the diverse communities living in our region.

Our focus has been on developing targeted strategies to meaningfully engage residents who face barriers to participation.

We then develop specific, customized strategies–designed in collaboration with the members of a target community–for engaging community members in a dialogue about their health and health care.

→ Mount Dennis Community

The TC LHIN partnered with Patient Destiny, a patient-led group, to engage residents of Toronto's Mount Dennis neighbourhood in discussions about health care needs and services in their area. We reached out to populations within this community that have unique health and wellness needs and challenges: new immigrants; single-parent families; and at-risk seniors from across ethno-cultural groups.

In order to build trust and get to the real issues, engagement took place at three levels. The first was to talk to community organizations including: Humber Community Seniors' Services, The Learning Enrichment Foundation, Somali Immigrant Women's Association (SIWA), Bala Avenue Community School, York Hispanic Centre and Les Centres d'Accueil Héritage. These meetings provided valuable information on the work and strategy-setting that had already been put in place throughout this community.

Specific meetings were held in the community. Invitations were translated in different languages and interpretation support was available. An evening cultural event hosted by SIWA focused on the distinct challenges experienced by Somali immigrants and generated recommendations about changes that the community thinks would make a difference. Les Centres d'Accueil Héritage hosted a focus group with Francophone clients at its Enhanced Adult Day Program.

Survey of St. James Town Residents, October 2012

- People overwhelmingly turn to primary care physicians for health issues (73.4%).
- Immigrants in St. James Town are more likely to see multiple providers (66.6%) and more likely to use walk-in clinics (54.9% vs 44.6%).
- Nearly 60% wait 2-3 weeks to get an appointment with primary care. Waits are longer for non-English speaking people and immigrants.
- Most people report some form of difficulty around communications with a health professional.

→ Health Access St. James Town

Health Access St. James Town was initiated as a collaborative effort among St. James Town residents, health care organizations, the City of Toronto, St. Michael's Hospital and the United Way to develop an integrated model for delivering services to this densely-populated neighbourhood.

Based on evidence and engagement of residents, health care providers and the city, this project will initially focus on improvements for vulnerable seniors, newcomers, children and youth and families.

In the summer of 2012, Community Animators, drawn from different ethno-cultural, linguistic and other identified communities including lesbian, gay, bisexual, transgender and youth, began to seek input from their communities. By fall 2012, Health Access St. James Town launched two initiatives to respond to community feedback – mental health and addictions programming for seniors and a mobile dental bus for low income residents.

Health Access St. James Town is a scalable model for public engagement in health service planning that can be adapted to other high-density and high-needs neighbourhoods.

A Mobile Dental Bus Rolls in to St. James Town

The popularity of the Dental Bus in St. James Town should be no surprise – the residents themselves identified access to affordable dental services as a priority during a recent round of community engagements.

What was different about the approach taken by Health Access St. James Town is that residents have a real say in planning health services for their community and are involved throughout the process of implementing and then evaluating the changes that they identified.

"The dental bus is really good. The staff are so friendly and helpful and they made my 18-month old son feel comfortable. It's really helpful and convenient to have (the dental bus) here and now I don't have to worry about getting to the dentist."

Orit, *St. James Town Resident*

TC LHIN's Board and the Community

Every Board meeting features presentations and discussions with community groups and stakeholders. The Board also goes out and participates in community tours to meet with citizens and patients in the areas where they live and work and where they receive health care services. For example, last year members of the Board volunteered with the Meals on Wheels program which took them into the heart of St. James Town and other inner-city neighbourhoods. They also toured the new campus at the Centre for Addiction and Mental Health to witness how it is changing the way we think about and provide mental health and addictions services in the city.

In May 2012, the Board hosted engagement sessions with Boards from all of the provider sectors and with local MPPs to discuss the health system changes underway and on the horizon.

Working with Providers and Community Partners

Every TC LHIN initiative involves significant engagement of and participation by providers and health professionals. The Health Professionals Advisory Committee (HPAC) is a key group because it brings forward a variety of clinical and health professional perspectives to the TC LHIN.

CEOs and executive directors from each provider sector meet as a group with the TC LHIN at least four times a year to review their performance on accountability agreement targets, to problem-solve and to agree on strategies to improve the quality of care.

And the Health Provider Leadership Forum brings the chief executives from all sectors around the table to advance common health system initiatives, including a common health system Emergency Management Plan for the TC LHIN and a shared language and interpretation service.

The first four Health Links meet regularly with the TC LHIN to share successes and to pursue joint activities, such as a standard discharge planning summary which will support patients once they leave the hospital.

The TC LHIN's three primary care physician advisors Dr. Phil Ellison, Dr. Yoel Abells and Dr. Tara Kiran led extensive consultations with primary care providers from all types of practices in support of the TC LHIN's Primary Care Strategy.

The TC LHIN's ED lead, Dr. Howard Ovens, and Critical Care lead, Dr. Niall Ferguson, work closely with clinicians on strategies to improve patient flow, ER wait times and patient access to appropriate hospital and community care.

2012/13: A Year of Progress

Over the last year, the TC LHIN released its Integrated Health Service Plan (IHSP-3) which sets the course for the health system over the next three years. The IHSP-3 builds on the directions in Ontario's Action Plan for Health Care and supports major provincial directions, such as Health Links.

→ Strategic Aim: Transform the system to achieve better health outcomes for people now and in the future.

The five IHSP-3 Strategic Priorities address the most urgent local health needs and offer the greatest opportunity for system change to meet our goals for patients.

1. Address the needs of the 1% of highly complex patients with the greatest needs, requiring the most resources.
2. Prevent and delay serious illness and injury among those who are at greatest risk of declining health.
3. Improve the patient experience.
4. Deliver value and sustainability through efficient use of resources.
5. Sustain our gains.

Priorities 1 & 2

Address the needs of the 1% of highly complex patients with the greatest needs, requiring the most resources. Prevent and delay serious illness and injury among those who are at greatest risk of declining health.

Primary care is the backbone of the health care system and plays a critical role in maintaining people's health and preventing or delaying serious illness and disability. Family physicians and other primary care providers are the most constant relationship that many people have in the health care system.

Primary Care

Family physicians and other primary care providers are people's gateway to the health care system.

However, many people in the TC LHIN do not have a primary care provider and those who have a family doctor cannot get an appointment when they need medical attention.

There are **1,126 primary care physicians** in the TC LHIN practicing in a variety of settings including multidisciplinary teams (such as Community Health Centres and Family Health Teams) as well as solo practices. Most physicians are not operating as part of a team. While there is a high concentration of primary care in the downtown core, there are fewer providers in certain areas of the TC LHIN, especially in the west end. Another challenge is that primary care providers are not well connected to hospitals and community health services and have difficulty referring patients to specialists and other services.

The TC LHIN has the highest proportion of adults without primary care in the GTA. Our region also has the lowest percentage of patients who visit their family physician within seven days of discharge from hospital.

This is partly because over 50 percent of the primary care services in the TC LHIN are provided to people who live in the GTA and local family physicians are less able to take on residents in their surrounding communities. Many of the city's family physicians also practice part-time, and an estimated 41 percent are over the age of 59 and are considering retirement in the next decade.

In 2012/13, the **TC LHIN led a strategy to improve access to primary care services.**

There are many primary care providers in Toronto who are providing comprehensive care to thousands of patients and families. Community Health Centres, the Sherbourne Health Centre's Health Bus and groups like Inner City Health Associates are leaders in serving vulnerable populations. The **TC LHIN's Primary Care Strategy** builds on these strengths while improving the way services are coordinated as people move between primary care, specialists and other providers.

The TC LHIN undertook a review of primary care in the region and sought advice from over 250 people – experts, primary care providers, health care organizations, patients and community leaders. A blueprint for improving primary care was announced in December 2012, with an initial focus on integrating primary care with hospital, home and community care within local or "sub-LHIN" areas for the most complex patients.

What we found is that some neighbourhoods in the TC LHIN that have significant poverty and many new immigrants, have little or no primary care in their communities. Primary care tends to be clustered in certain parts of the city such as the downtown core. Neighbourhoods – including St. James Town and Regent Park that have a relatively high proportion of primary care providers close by – have the highest number of people who are readmitted to hospital soon after being discharged as well as the highest ED visits for non-urgent reasons. This indicates that some people who live in these communities are not receiving adequate primary care and other services in their communities.

"South of Lawrence Avenue, there is a stark lack of medical supports, meaning that people must travel for prescriptions. The few resources that are available are limited, not accepting patients or people are not aware of these services. For those who choose to forgo access rather than travel, small ailments become much larger before they are addressed and regular check-ups can be neglected."

The Community We Want: 2012 Weston Mount Dennis Survey Results, Learning Enrichment Foundation

Over the past year, the Primary Care Physician Advisors worked with primary care providers across the TC LHIN to find ways to connect people without a family physician to primary care, focusing on high-needs patients.

Ten percent more people who were without a primary care provider were connected to a family physician through Health Care Connects since October 2012. And 17 percent more vulnerable patients were connected to primary care during this time.

Health Links

In December 2012, the Ministry of Health and Long-Term Care announced the creation of Health Links to coordinate health services in local areas. Health Links are groups of providers that coordinate services for people who live in their area. Health Links are the key means to address the problems identified in the TC LHIN's primary care strategy. There will be nine Health Links in TC LHIN. **The first four Health Links have been established. By 2015, all nine will be fully implemented.**

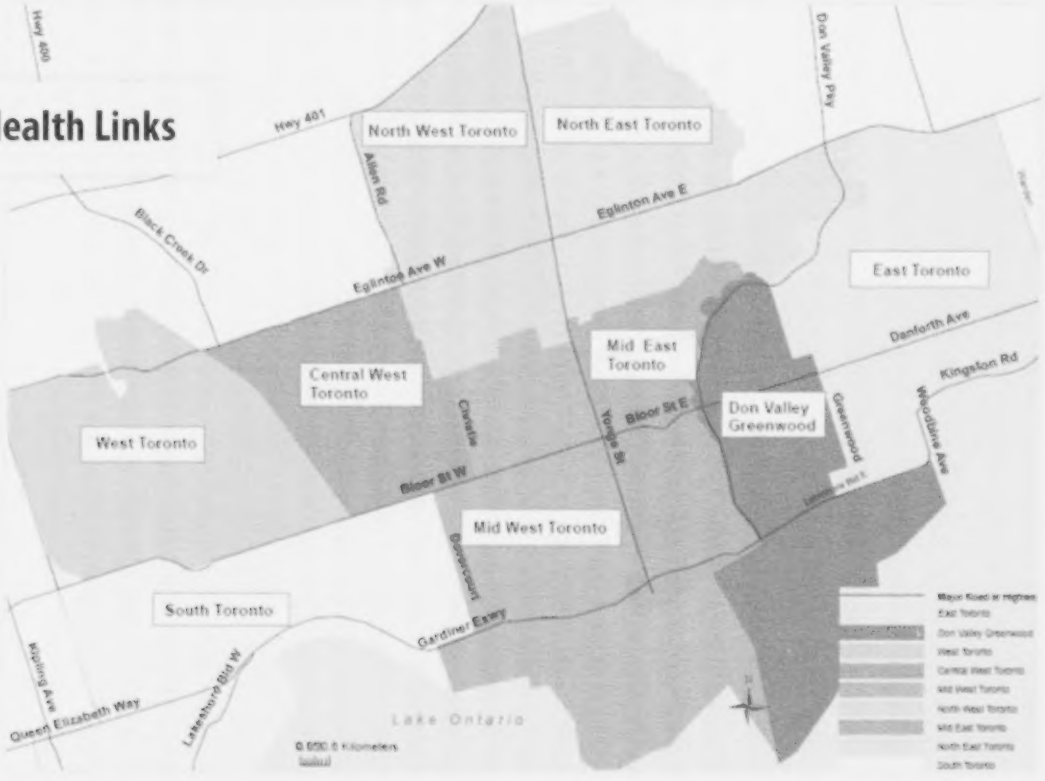
What Health Links Mean for Patients

- Faster care and less time waiting for services and referrals.
- Same day/next day access to their primary care provider.
- Smoother transitions through the health care system.
- Support from a team of health care providers at all levels of the health care system.
- Care that responds to their specific needs.

Health Links will start by focusing on those who have the greatest needs and use the most health services. Complex patients need all providers to work as a coordinated team. However, too many of these individuals encounter obstacles as they move from one service to another. They find the health care experience to be disorganized and confusing.

Too often they suffer avoidable problems such as medication errors, infections, and debilitating pain. Many are in and out of hospital or prematurely admitted to long-term care when it would be better for them

The Nine Health Links



– and they would prefer – to receive care in their communities and homes.

High quality care costs less than poor quality care. By improving the care of complex patients – and reducing their need for expensive services – we will free up funding to be reinvested in more primary and community-based health care for everyone. We will also have more money to put into preventative measures such as supportive housing, nutrition and recreation programs, screening, counselling and patient self-management programs.

All Health Links will be accountable for achieving all the provincial objectives. Health Links in the TC LHIN, however, are focusing immediately on three improvements in addition to local priorities:

1. Providing all complex patients with a primary care provider.
2. Providing each complex client with a coordinated care plan.
3. Ensuring complex clients see a primary care provider within seven days of being discharged from hospital.

The TC LHIN is providing a number of supports to primary care physician and other providers. For example, we are developing a standard discharge summary with meaningful and comprehensive information about the patient once they are discharged from hospital. This information will go directly to a patient's primary care provider and the CCAC. Some hospitals will begin to send this information electronically in 2013/14.

In addition to integrating all health care providers within "sub-LHIN areas," the TC LHIN is working with the university and college sector to enable innovative, community-based training opportunities to prepare future health professionals.

Given that 75 percent of health is influenced by factors outside of the health care system, the long-term plan for Health Links is to bring together the key sectors that influence population health to coordinate planning and service delivery.

The LHIN also started to meet with social service partners such as the United Way, the Ministry of Community and Social Services, and the City of Toronto to explore ways to integrate planning efforts. Initial discussions will focus on the at-risk populations who, in the absence of adequate social and economic supports, will experience failing health and require more high-cost health care down the road.

Investing in Community Health Care

Community health services play a critical role in people's health and wellbeing.

Investing in community health care is a priority in the government's Action Plan for Health Care and in the IHSP-3.

Agencies that provide community support and mental health and addictions services are serving an ever-more complex and diverse group of clients, many of whom

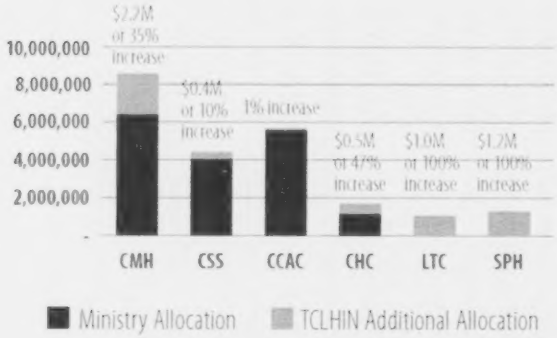
expect to be active and informed participants in their care. However, as a whole, community-based health providers are not yet organized and equipped to provide the level of care that our population requires.

The TC LHIN has 67 community support service organizations and 69 community mental health and addictions agencies. Even though there is an abundance of agencies, seniors and other community members, as well as primary care providers, say they don't know what services are available in their communities. Family physicians find it complicated and time-consuming to try to get clients into community health programs. Also, the fact that many of the agencies only operate Monday to Friday and during the day is problematic for people with mental illness and addictions, the frail elderly and overburdened caregivers.

Initiatives to create single access points and phone numbers to access community health services in the TC LHIN are starting to address these challenges, however service gaps remain.

Last year the Ministry increased funding for home and community care by four percent. The TC LHIN added to this $17 M increase with another $5.4 M for **a total investment of $22.4 M in community-based health services last year.**

2012-13 Discretionary Funding for Ministry allocation ($17 M) and TC LHIN additional allocation to community sectors ($5 M) for a grand total of ($22 M)



As a result of community investment, **18 new or expanded services** for frail older adults, people with mental illness and addictions, Aboriginal women, and adults with multiple chronic conditions are enabling people to receive care close to home and enjoy a better quality of life.

The TC LHIN also earmarked part of this funding to assist the community health sectors to **build critical infrastructure and lower costs.**

18 community agencies have started the process by taking a coordinated approach to IT purchases, already yielding an overall savings of 18% or $70,000.

Community Health Investment – Highlights

Coordinated Access to Care from Hospital - CATCH ED

For many people struggling with mental illness and addictions, accessing health care is one more hardship on top of their health challenges.

TC LHIN's Coordinated Access to Care from Hospital (CATCH-ED) program was piloted last year to help prevent people with mental illness and addictions from going to the ED to access health care that they could receive in the community. This program was built on an earlier program for the homeless. The TC LHIN partnered with six Toronto hospitals, four community mental health agencies and four community health centres. Transitional Case Managers go into EDs and help patients connect with the community health care services they need. This program assists clients with other needs, including housing and income support.

Mobile Crisis Intervention Team

The TC LHIN launched a new Mobile Crisis Intervention Team (MCIT) in east Toronto. MCITs match up health nurses with police to assist people who are experiencing a mental health crisis. The TC LHIN asked Rob Devitt, CEO Toronto East General Hospital and Michael Frederico, Toronto Police Deputy Chief to lead a plan for making these teams available in all Toronto neighbourhoods.

Behavioural Supports Ontario (BSO) Strategy

A number of high profile incidents of violence involving long-term care residents have fueled public debate about the health system's readiness to care for people with challenging behaviours.

The LHINs have recognized there is a serious gap in the health care system and are working on a province-wide initiative to put more effective services in place for older adults with behavioural challenges.

As part of this, the TC LHIN launched the Behavioural Supports for Seniors Program (BSSP) in Fall 2012. The BSSP improves the quality of life of individuals with challenging behaviours associated with dementia, mental illness, addictions and neurological conditions, by providing a safe and supportive environment and specialized care for them and their families. The program includes a Transitional Behavioural Support Unit at Baycrest, new and enhanced outreach teams in the community, and education and training for health professionals and families.

Priority 3

Improving the patient experience – through quality, equity and engagement.

Improving Quality Across the System

With the province's *Excellent Care for All* legislation, hospitals and, in time, all health care providers, will have a higher level of accountability for improving quality of care. Quality improvement for patients and clients is also a primary goal in the HSP-3.

The TC LHIN has a three-part strategy to improve the quality of health care in the region:

1. Creating and improving common quality indicators for the system.
2. Measuring and driving improvements in the patient experience.
3. Ensuring *Excellent Care for All* by addressing health equity.

→ Quality Indicators

The Institute for Healthcare Improvement (IHI) in the United States, an internationally recognized authority in health quality improvement, recommends that health systems focus on a few specific and high-impact system indicators.

The TC LHIN brought all providers, quality improvement experts and patient advisors together to select quality improvements for which all providers will be accountable. The TC LHIN embraced quality indicators developed by Health Quality Ontario and, out of these indicators, selected six "Big Dot" indicators for the TC LHIN that depend on all parts of the system working together and relate to patient transitions between providers.

The Toronto Central LHIN's Six Big Dot Indicators:

Theme: Appropriate Access to Care –Focusing on avoidable time in hospital and ED

1. Inpatient unscheduled readmissions within 30 days of discharge for select conditions including:
   - Stroke
   - Chronic obstructive pulmonary disease
   - Congestive heart failure
   - Cardiac diseases
   - Pneumonia
   - Diabetes
   - Gastrointestinal
   - Asthma
   - Mental health and addictions
2. Repeat unscheduled ED use within 30 days for any reason especially for lower acuity patients.

Theme: Transitions of Care – Focusing on patient experience during transitions and the length of time waiting for care

3. Percentage of hospital patients (ED or inpatient) who knew important discharge aspects. For example, danger signals to watch after going home, medication related information, when to resume usual activities or who to call if they need help.
4. 90th percentile decision time which is the number of days from the date that the referral is sent to the final response by the receiving agency.
5. 90th Percentile waiting time from the time a patient is accepted to rehab, CCC, LTC, CCAC, CSS or CMHA to when they receive care.

Theme: Care for Patients with Complex and High Care Needs

6. Percent of patients with complex high care needs identified that are targeted/receiving appropriate care.

By the end of 2012/13, all sectors committed to the Big Dot Indicators and identified indicators in their own sectors that contribute to these big system improvement goals.

→ Measuring the Patient Experience

Most problems occur for patients when they move from one service to another. Yet there is little information and attention towards the patient experience across the care journey. The TC LHIN conducted 50 engagements with over 30 providers to learn how they measure and improve the patient experience. We found there are vast inconsistencies in how agencies collect and report this information. Patient feedback is only in English or French and focuses on a single health care experience.

The TC LHIN's Patient Experience Measurement Initiative aims to improve measurement of patient experience by standardizing the type of information that is measured by health care organizations. We took two important actions last year.

A common email survey tool piloted at St. Joseph's Health Centre will enable patients to provide their feedback in specific terms, at or close to the time they are receiving care.

The 32 community support agencies involved in Community Navigation and Access Program (CNAP) are working to standardize the way they measure the client experience. The first step is creating a common survey tool to evaluate seniors' satisfaction with health care.

→ Equity – Excellent Care for All

Collecting Vital Health Information to Measure Health Equity

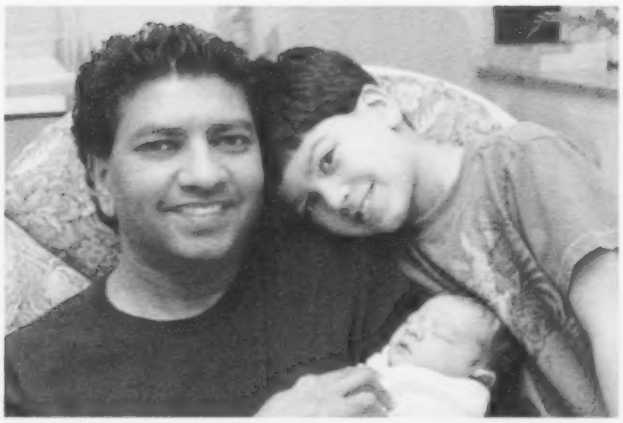
With the elimination of the Statistics Canada long census form, Canada has lost a vital source of information about the population that could be used to measure health disparities. The TC LHIN is investing in an initiative that will allow us to systematically measure health equity for the first time.

Based on results of a three-year project of Mount Sinai Hospital, the Centre for Addiction and Mental Health, St. Michael's Hospital and Toronto Public Health, TC LHIN has mandated all TC LHIN hospitals to collect patient-level demographic data, beginning in each hospital by

All hospitals will ask patients a key set of questions to determine their socio-demographic backgrounds:

- What language do you feel most comfortable speaking in with your health care provider?
- Were you born in Canada? (If no, what year did you arrive?)
- Which of the following would best describe your racial or ethnic group?
- Do you have any of the following disabilities? (list)
- What is your gender?
- What is your sexual orientation?
- What was your total family income before taxes last year?

Note that the full questionnaire asks more detailed questions related to these 7 areas.



Priority 4

Deliver value and sustainability through efficient use of resources.

April 2, 2013. This first-in-Canada regional approach to equity measurement is a best practice in other parts of the world and will:

- Indentify who is receiving care;
- Help delineate differences in access, outcomes, and quality of care between different population groups;
- Allow analysis of quality measures by demographics (e.g. re-admission rates, diabetes, cancer screening, etc.);
- Enable the development of evidence-based quality improvement strategies for reducing health inequities.

This information will also uncover why certain neighbourhoods and populations have different patterns of health care use including ER visits and access to primary care.

Language Services Toronto

Last year the TC LHIN launched Language Services Toronto, a GTA-wide service that links non-English speaking patients with doctors, nurses and other health professionals with the aid of a telephone interpreter.

- 17 hospitals and 15 community agencies now offer phone interpretation through this program.
- In February 2013, the consortium reached over 37,000 minutes of telephone interpretation.
- Available in over 170 languages.
- Sharing the cost has reduced rates at some hospitals by up to 80%; savings reinvested in patient care.

New Models of Care

The Toronto Central LHIN is bringing providers from across the system together to improve clinical care to, and to gain efficiencies through, integration and new approaches to service delivery. Two of the first clinical integration initiatives out of the gate this year are reorganizing the delivery of stroke and hip and knee rehabilitation.

So far, stroke services have been expanded to fill identified gaps. There was an agreement to shift resources from Mount Sinai and Toronto General Hospitals to Toronto Western Hospital to create a critical mass of stroke expertise at the Toronto Western site.

This past winter, the TC LHIN launched the Walk-In Stroke Protocol for walk-in patients arriving at a community hospital ED. People arriving at their local hospital suffering from a stroke will be eligible for quick transport to one of three Regional Stroke Centres – St. Michael's, Sunnybrook or UHN – for specialized stroke care. Once they no longer require the special services of the Regional Stroke Centre, they will be repatriated back to their local hospital for care.

In an effort to meet best practices by getting hip and knee replacement patients into rehabilitation and recovery sooner, outpatient services are being enhanced in a number of organizations, including Bridgepoint Health. The number of hip and knee replacement patients discharged home increased from 64 percent in 2010/11 to 81 percent by Fall 2012. A full plan for redesigning stroke and orthopedic rehabilitation services will be completed in 2013/14.

Other Activities to Advance Health System Integration

Activity	Impact
Clinical Integrations	
Hospital-based Withdrawal Management In 2012 the TC LHIN took important measures to fill some gaps in withdrawal management services while initiating a review of addictions service capacity in Toronto.	▪ The TC LHIN is working with St. Michael's and University Health Network (UHN) on a collaborative model to improve access to withdrawal management services provided by the hospitals. ▪ The TC LHIN provided base funding for Toronto East General Hospital's (TEGH) Aboriginal withdrawal management program. It also provided one-time funds for up to a year and a half in support of TEGH's Scarborough day program to maintain services while base funding for the program is being secured and Central East LHIN develops a plan for withdrawal management services in Scarborough. ▪ The TC LHIN is working with the Ministry of Health and Long-Term Care and Canterbury – a major private addictions agency specializing in Oxycontin withdrawal – to maintain these services while the TC LHIN develops a system plan for addictions services.
Foot and Ankle Surgery Foot and ankle surgery currently has a wait time of over 400 days in the TC LHIN – creating significant access issues to the patients who need this service. In 2012/13 the TC LHIN received funding to increase capacity at two hospitals (UHN and St. Michael's) while we work toward a model that centralizes access for patients from across Ontario coming to TC LHIN for this complex surgery.	The provincial triage and assessment programs will be developed to: ▪ Improve patient care and ensure efficient use of resources. ▪ Redirect less complex patients that can be managed in the patients local communities. ▪ Increase clinical and operational capacity through coordinated planning. ▪ Develop a simple yet effective data collection system to monitor and evaluate program performance.
Cardiac Care The TC LHIN has convened an Academic Health Science Centre Cardiac Care Committee to develop a coordinated cardiac care plan.	▪ The goal is to strengthen all organizations. ▪ This initiative will also plan for emerging infrastructure/technology. ▪ Patient choice and other cross-LHIN issues will be addressed.
Forensic Mental Health Current services are not keeping pace with demand. The TC LHIN is working with the Ministry to create a forum to address province-wide forensic mental health capacity to implement appropriate performance measures.	▪ A forum that brings all players to the table is a key step to address this pressing health system issue.
Corneal Transplants The TC LHIN worked with the Ministry to create capacity for additional corneal transplants for this fiscal year.	▪ The TC LHIN wait times for corneal transplants have improved this year.

Activity	Impact
Vision Care Plan TC LHIN is participating with/partnering with the Kensington Eye Institute (KEI) and the University of Toronto Department of Ophthalmology to develop a comprehensive vision care plan.	▪ A plan to strengthen the bridges between the Kensington Eye Institute, the hospitals and the University of Toronto in the delivery of in-hospital and out-patient ophthalmology services. ▪ The goal is to increase overall system capacity, surgical efficiency at KEI and hospital operating room tertiary care capacity.
MRI Rapid Testing The TC LHIN invested $750,000 in one-time funds for the UHN to pilot a rapid testing model for MRIs. A report is due to the LHIN in May 2013.	▪ Rapid testing will help to sustain recent success in improving MRI wait times.
Environmental Health The TC LHIN is involved with two projects related to the Environmental Health Clinic (EHC). With the opening of the new Women's College Hospital (WCH), the existing EHC had to be relocated to a new location.	▪ The TC LHIN undertook considerable stakeholder engagement which resulted in a diverse group of stakeholders agreeing on a future plan to relocate the clinic. Concurrently, a provincial process is underway to develop a hub and spoke model for Environmental Health including a Centre of Excellence located in the TC LHIN.
Voluntary Integrations	
University Health Network and Toronto Rehabilitation Institute	This merger has already saved over $3 M which is being reinvested in services including rehab for the elderly with hip fractures. UHN has also been able to reinvest savings in expanding the hospital's fast-track stroke clinic. Staff and patient satisfaction at the hospital has been maintained and improved in some areas.
Sunnybrook Health Sciences Centre and St. John Rehabilitation Hospital ▪ This merger came into effect in July 2012.	In the first six months post-merger, Sunnybrook has achieved savings related to administration and overhead which will be reinvested for the St. John's site to achieve a balanced budget. Any remaining funds will be allocated to rehabilitation best practices. Sunnybrook has maintained its patient referrals from all partner hospitals. During this period, Sunnybrook has made significant progress in: ▪ Integrating infrastructure and support services; ▪ Updating the organization structure; ▪ Executing on the first phase of the human resources plan for corporate and non-union staff.
WoodGreen and Community Care East York Merger	A year after its merger with Community Care East York, WoodGreen is providing seniors, people with disabilities, immigrants and others with more services within the same overall budget: ▪ Case management/counseling have increased by 10%; ▪ Social Recreational Programs have increased by 25%; ▪ Social & Congregate Dining has increased by 20%; ▪ Volunteer services are up by 30%.

Other Activities to Advance Health System Integration *continued*

Activity	Impact
Good Shepherd Non-Profit Homes Inc. (GSNP) and Toronto Scarborough Hospital (TSH)	As of April 1, 2012, the management of a supportive housing unit to serve 10 individuals with complex mental health needs, 24/7 has been transferred from TSH to GSNP. Clients have benefitted from additional enhanced programs offered through GSNP.
Service Changes	
WCH's New Model of Care WCH is transforming its model of care, shifting away from their Urgent Care Centre model to expand ambulatory services for people with complex chronic diseases including congestive heart failure, asthma, and diabetes.	Early successes include: • "Navigation hub" – where a nurse and CCAC coordinator helps family physicians to connect to specialists, diagnostic testing and community resources and "Internist on call;" • A Virtual Ward for mental health and addictions to keep high-risk patients out of hospital. These and other programs will be leveraged by the Mid-West Toronto Health Link.
Providence Health Care – Transformation by Design • Providence has been integrating services with other hospitals and CCAC in order to support patients to get into rehabilitation and home sooner and safely. • Providence is reducing the number of beds in all its inpatient units and reinvesting these resources to support on-unit rehabilitation and onsite outpatient services. • Providence nurses are working inside acute care hospitals to support patients to transition to rehabilitation earlier. Providence's staff stays in touch with patients after they leave, make home visits and provide outpatient support.	More patients are being admitted to Providence Programs with fewer beds and stroke/neurology patients are getting home sooner without compromising clinical outcomes.
Improving efficiency and outcomes of cataract surgery	As of July 1, 2012, under the TC LHIN's leadership, all routine cataract surgeries were transferred from the Toronto Central academic health sciences centres to KEI. This will improve efficiency and put the right services in the right places, allowing hospital to concentrate on the complicated cases and improving wait times for cataract surgery.
Transfer of the Women's Health Centre program from St. Joseph's Health Centre (STJC) to Parkdale Community Health Centre (PCHC) On July 1, 2012, the Women's Health Centre Program was transferred from STJC to the PCHC.	Women – mostly newcomers, those living with mental illness and addictions and poverty – will have access to additional services offered at PCHC including dentistry, physiotherapy, legal clinics and primary care services.

Priority 5

Sustain Our Gains.

The TC LHIN has made marked progress over the last few years in reducing the amount of time people wait in the ED for treatment and for key surgeries and diagnostic tests. And we have significantly improved Alternate Level of Care(ALC) – the rate at which people remain in hospital when they no longer need to be there, waiting to be transferred back home, to long-term care or to another setting. Over the past year, we were able to sustain these improvements overall.

Getting People to the Right Place of Care

Integrated Client Care Project (ICCP) brings together different parts of the system to better meet the needs of clients who require the highest levels of care. ICCP expanded from 200 seniors to 1,500 frail/complex seniors. ICCP clients have benefits including:

- Intensive case management support from a CCAC Care Coordinator, who acts as a 'quarterback' for clients and caregivers, working hand-in-hand with the primary care provider and other members of an interdisciplinary team.
- Their own ED Transfer package at home that includes essential medical history information and medication lists to enable a safer and far easier experience when they have to call emergency services to go to the hospital.
- A single pharmacist/pharmacy in the community to help them manage their medications.

More supportive housing spaces for long-stay ALC clients enabled the transition over the last year of 72 people living with mental illness from long-stay ALC to supportive housing or other settings.

Daniel – Regeneration House Tenant

When Daniel was diagnosed with schizophrenia, his life changed forever. He was admitted to the Centre for Addiction and Mental Health (CAMH) where he stayed as an inpatient until he was ready to move on with his recovery. In the summer of 2012, he received keys to one of the 40 apartments at Regeneration Community's new supportive housing apartment.

The program provides tenants with support in the form of employment counselling, links to the local community health services, clinical support from CAMH, peer support, and recreational activities in the neighbourhood. This program reintegrates people back into community life. Providing people like Daniel with the most appropriate services has a positive impact on their recovery and wellbeing. It also benefits the health system by reducing the number of patients in hospital who no longer need this level of care. For the first time in years, Daniel is able to plan his future – thanks to the help and support he has received.

→ Long-Term Vent (LTV) Initiative

The TC LHIN and providers have implemented a strategy to get LTV clients to the right place of care. Now clients in the community have a single program with a dedicated care coordinator and nurse practitioners. There are four new enhanced beds at West Park Healthcare Centre. Tobias House will open new LTV supportive housing units in April 2013.

Health System Performance and Accountability

Toronto Central LHIN Performance Indicators 2012/13: Released May 13, 2013

PI No.	Performance Indicator	LHIN 2012/13 Starting Point	LHIN 2012/13 Performance Target	Most Recent Quarter LHIN 2012/13 Performance	FY 2012/13 LHIN Annual Result
Emergency Room / Alternate Level of Care					
1	Percentage of Alternate Level of Care (ALC) Days – by LHIN of Institution*	10.36%	10.00%	10.35%	10.64%
2	90th Percentile ER Length of Stay for Admitted Patients	25.88	23.00	26.35	25.73
3	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	8.10	8.00	7.75	7.82
4	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4.88	4.50	4.58	4.63
Surgical Wait Times					
5	90th Percentile Wait Times for Cancer Surgery	62	62	56	56
6	90th Percentile Wait Times for Cardiac By-Pass Procedures	46	44	43	39
7	90th Percentile Wait Times for Cataract Surgery	117	110	141	127
8	90th Percentile Wait Times for Hip Replacement	155	170	181	181
9	90th Percentile Wait Times for Knee Replacement	174	170	211	229
Diagnostic Wait Times					
10	90th Percentile Wait Times for Diagnostic MRI Scan	98	110	80	96
11	90th Percentile Wait Times for Diagnostic CT Scan	39	39	36	38
Excellent Care for All / Quality					
12	Readmission Within 30 Days for Selected CMGs**	18.89%	18.00%	18.30%	18.63%
Mental Health and Substance Abuse					
13	Repeat Unscheduled Emergency Visits Within 30 Days for Mental Health Conditions**	24.62%	25.00%	27.77%	26.11%
14	Repeat Unscheduled Emergency Visits Within 30 Days for Substance Abuse Conditions**	37.43%	35.00%	36.18%	37.24%
Access to Community Care					
15	90th Percentile Wait Time for CCAC In-Home Services – Application from Community Setting to First CCAC Service (Excluding Case Management)*	33	30	31	36

* FY 2012/13 is based on most recent four quarters of data (Q4 2011/12 - Q3 2012/13) due to availability

**FY 2012/13 is based on most recent four quarters of data (Q3 2011/12 - Q2 2012/13) due to availability

Table Legend

- Within the performance corridor;
- Outside corridor but an improvement over 2011/12 performance;
- Outside corridor and worsening from the 2011/12 performance

Mental Health and Addictions – Coordinated Access for Clients

Coordinated Access Points

In 2012, the TC LHIN and mental health and addictions agencies provided a single access point for clients requiring services such as case management and Assertive Community Treatment Teams (ACTT) through a program called Access-1. And for the first time there is only one phone number to call for referrals to key mental health services. Last year, 742 individuals in the GTA were supported through Access-1 and 23 mental health service providers are participating.

Coordinated Access for Addictions Services Pilot

In Q1 2012/13, the TC LHIN launched a similar coordinated access pilot for addictions. Call volumes were on a steady rise since implementation but have plateaued in Q3. An awareness building strategy should improve uptake and this work will be incorporated into Health Links and community mental health and addictions service planning.

Telemedicine and Telehomecare

Technology is also giving people more choice in how and where they receive health care; and opening up new possibilities for self-care.

Two innovative telemedicine models were developed in TC LHIN last year:

1. Toronto East General Hospital's Withdrawal Management Service is allowing patients to receive medical clearance for withdrawal management services virtually instead of having to visit an Emergency Department for clearance.
2. TC CCAC's TeleWoundcare Project - Ontario Telemedicine Network technology together with a telemedicine registered nurse will provide timely access to wound specialists for individuals with chronic diseases.

Although the telehomecare initiative got off to a slower start than planned, the program has ramped up since November 2012 and an awareness-building campaign contributed to increased enrollment in the last half of the year.

The TC LHIN negotiated its Ministry-LHIN Accountability Agreement (MLPA) targets with the Ministry in August 2012. Some of the targets have been revised and now more accurately reflect the outcomes people should expect based on evidence and experience. The LHINs will now report on whether they are within a 10 percent "acceptable performance range" which means they are within 10 percent of achieving the targets.

This is important because it acknowledges where performance is very close to target (within days, hours and even minutes) and provides a more nuanced representation of performance than a "met or did not meet target" assessment.

It is also important to look at the performance trend over time rather than only at specific points in time. Wait times for cardiac, cancer, hip and knee and cataract surgeries and for CT scans have improved dramatically over the last seven years. ER wait times have also steadily improved over the last four years since access to ER has become a health system priority.

Performance Highlights

Improved Performance

The TC LHIN is currently green for 11 MLPA indicators in 2012/13 compared to the 2011/12 results. Performance continues to improve for ER wait times for complex patients and patients with minor conditions who are not admitted to hospital. Wait times for MRI and CT scans, cardiac by-pass and cancer surgeries, and for clients referred to home care from the community have also improved this past year as a result of collaboration among hospitals, community agencies and long-term care.

Indicator: Readmission Rates

Although we are green for this indicator, the TC LHIN continues to have high hospital readmission rates within 30 days of discharge. In Q1 2012/13, the TC LHIN had the second highest readmission rates of all LHINs, at 18.61 percent. This can be explained in part by the complexity of patients in TC LHIN hospitals. Other factors, such as lack of access to primary and community care among vulnerable

residents and the high proportion of people living with mental illness and addictions in the city, contribute to avoidable hospital readmissions. Strategies underway, including Health Links and building the community sector's capacity, are addressing the underlying issues.

→ Fairly Stable Performance

The percentage of ALC days and repeat unscheduled ED visits for substance abuse conditions were red in 2011/12 and green for 2012/13 as the performance is within acceptable range. Repeat unscheduled ED visits for mental health conditions was green in both 2011/12 and 2012/13.

→ Worsened Performance

TC LHIN wait times for hip and knees replacement and cataract surgery have increased in 2012/13 compared to 2011/12. Increased demand and patient preference continue to influence wait times. In fact, when people waiting for preferred orthopaedic surgeons are not included in the count, the majority of patients are waiting within the recommended target. Efforts to redesign hip and knee replacement rehabilitation and expand outpatient services in Toronto are helping to get people out of hospital and into rehabilitation sooner.

Looking Ahead to 2013/14

Health Links

We will work to get all nine Health Links moving forward over the next year. We expect that patients will begin to notice a difference soon. More complex clients will have their own primary care provider and we expect to see marked improvement in the numbers who see a primary care provider less than one week after they leave the hospital. These clients will also be supported by a care coordinator or case manager who will make sure they receive all the services they require.

Better Services for Complex and At-Risk Clients

This year, the TC LHIN is leading an initiative to improve and expand key services for complex and at-risk clients. Informed by clients and caregivers, providers and the latest evidence, these improvements will include:

- Central hubs and a single phone number available 24/7 to make it easier for primary care providers to refer clients to community support and mental health and addictions services and for clients to access these services directly.
- Community services for complex and at-risk clients available during the night and weekends.
- A care coordinator responsible for coordinating services for each complex and at-risk client.
- Easier referral process to appropriate specialist services and diagnostic imaging (e.g., MRIs and CT scans). Each hospital will have a single contact for all specialist appointments, and automated client referrals and scheduling.

Public Reporting

Over the next year, the TC LHIN will launch a public report on health care performance. This online report will provide greater insight into health services in the LHIN and shine a light on areas requiring attention and improvement.

Improving Population Health

We will pursue partnerships to improve the health and wellbeing of the population as a whole. For example, the TC LHIN's newly created Strategic Advisory Committee, which draws together representatives from health, education, social services, the City of Toronto and provincial government, will be one way to collectively address health and wellness in the city, including seniors' care and promoting children's and youth's physical and mental health.

Our Board of Directors

Name	Position	Appointed	End of Term	Length of Term
Ferrante, Angela	Chair	November 3, 2010	November 2, 2013	3 years
Blickstead, Richard	Director	November 3, 2010	November 2, 2013	3 years
Coyles, Stephanie	Director	October 29, 2008 November 25, 2011	October 28, 2011 November 24, 2012	3 years 1 year
Fraser, John	Director	June 27, 2011	June 26, 2014	3 years
Gallagher-Ross, Kathleen	Director	April 18, 2011	April 17, 2014	3 years
Komori, Lloyd	Director	August 21, 2008 August 21, 2011	August 20, 2011 August 20, 2014	3 years 3 years
Magill, Dennis	Director	March 7, 2007 March 7, 2010	March 6, 2010 March 6, 2013	3 years 3 years
Pay, Cynthia	Director	December 21, 2012	December 20, 2015	3 years
Perry, Carol	Director	June 2, 2011	June 1, 2014	3 years
Virmani, Anju	Director	May 14, 2008 May 14, 2011	May 13, 2011 May 13, 2012	3 years 1 year

*Please note: The TC LHIN has nine Board Members at any one time.

Angela Ferrante
Chair

Richard Blickstead
Director

Stephanie Coyles
Director

John Fraser
Director

Kathleen Gallagher-Ross
Director

Lloyd Komori
Director

Dennis Magill
Director

Cynthia Pay
Director

Carol Perry
Director

Anju Virmani Kumar
Director

Deloitte

Deloitte LLP
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Independent Auditor's Report

To the Members of the Board of Directors of the
Toronto Central Local Health Integration Network

We have audited the accompanying financial statements of the Toronto Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2013, and the statements of financial activities, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2013, and the results of its financial activities, change in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
June 5, 2013

Toronto Central Local Health Integration Network

Statement of financial position
as at March 31, 2013

	2013	2012
	$	$
Financial assets		
Cash	**1,307,144**	392,175
Due from Local Health Integration Networks ("LHINs")	**42,230**	301,836
Due from Ministry of Health and Long-Term Care ("MOHLTC") regarding HSP transfer payments	**30,147,046**	13,537,634
Harmonized Sales Tax receivable	**442,966**	574,623
	31,939,386	14,806,268
Liabilities		
Accounts payable and accrued liabilities	**1,715,591**	1,383,215
Due to HSPs	**30,147,046**	13,537,634
Due to MOHLTC (Note 4b)	**145,816**	1,297
Deferred capital contributions (Note 5)	**1,801,524**	1,640,726
	33,809,977	16,562,872
Net debt	**1,870,591**	1,756,604
Commitments (Note 24)		
Non-financial assets		
Prepaid expenses	**69,067**	115,878
Tangible capital assets (Note 6)	**1,801,524**	1,640,726
	1,870,591	1,756,604
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

Toronto Central Local Health Integration Network

Statement of financial activities
year ended March 31, 2013

	Budget (Note 7)	2013 Actual	2012 Actual
	$	$	$
Revenue			
Ministry of Health and Long-Term Care ("MOHLTC") funding	5,535,121	5,288,433	5,559,386
Ministry of Health and Long-Term Care ("MOHLTC") funding to LHINC	636,500	670,000	670,000
MOHLTC Funding to LHIN Shared Services Offices ("LSSO")	700,000	740,000	-
Health Service Provider ("HSP") transfer payments (Note 8)	4,425,789,274	4,639,988,705	4,506,874,309
Enabling Technologies (Note 9)	510,000	580,000	600,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000
Aboriginal Health Transition Planning (Note 11)	20,000	20,000	27,500
Emergency Room and Alternate Level of Care ("ER/ALC") (Note 12)	100,000	100,000	100,000
Critical Care ("CC") Leads (Note 13)	75,000	75,000	75,000
Resources Matching Referrals Leads (Note 14)	423,200	483,000	387,000
French Language Health Services ("FLHS") (Note 15)	106,000	106,000	106,000
French Planning Entities (Note 16)	568,713	421,475	568,713
Primary Care Lead (Note 17)	75,000	75,000	21,875
Behaviour Support Ontario	-	-	57,000
Diabetes Regional Coordination Centre (Note 18)	-	21,566	-
Amortization of deferred capital contributions (Note 5)	-	740,573	482,142
Amounts recovered/recoverable from the LHINs to LHINC	617,500	355,647	354,558
Amounts recovered/recoverable from the LHINs to LSSO	4,781,284	4,758,177	4,756,393
	4,440,012,592	4,654,498,576	4,520,714,876
Funding repayable to the MOHLTC related to operations (Note 4a)	-	(1,578)	(1,297)
	4,440,012,592	4,654,496,998	4,520,713,579
Expenses			
Transfer payments to HSPs (Note 8)	4,425,789,274	4,639,988,705	4,506,874,309
General and administrative (Note 19)	5,535,121	5,431,373	5,700,352
LHIN Shared Services Office (Note 20)	5,481,284	6,094,232	5,096,272
LHIN Collaborative (Note 21)	1,254,000	1,025,647	1,024,558
Enabling Technologies (Note 9)	510,000	580,000	600,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000
Aboriginal Health Transition Planning (Note 11)	20,000	20,000	27,500
Emergency Room and Alternate Level of Care (ER/ALC) (Note 12)	100,000	100,000	100,000
Critical Care ("CC") Leads (Note 13)	75,000	75,000	75,000
Resources Matching Referrals Leads (Note 14)	423,200	483,000	387,000
French Language Health Services ("FLHS") (Note 15)	106,000	106,000	106,000
French Planning Entities (Note 16)	568,713	421,475	568,713
Primary Care Lead (Note 17)	75,000	75,000	21,875
Behaviour Support Ontario	-	-	57,000
Diabetes Regional Coordination Centre (Note 18)	-	21,566	-
	4,440,012,592	4,654,496,998	4,520,713,579
Annual surplus and accumulated surplus, end of year	-	-	-

Toronto Central Local Health Integration Network

Statement of change in net debt
year ended March 31, 2013

	2013	2012
	$	$
Annual surplus	-	-
Acquisition of tangible capital assets	**(901,371)**	(1,657,777)
Amortization of tangible capital assets	**740,573**	482,142
Acquisition of prepaid expenses	**(69,067)**	(115,878)
Use of prepaid expenses	**115,878**	92,496
Increase in net debt	**(113,987)**	(1,199,017)
Net debt, beginnng of year	**(1,756,604)**	(557,587)
Net debt, end of year	**(1,870,591)**	(1,756,604)

Statement of cash flows
year ended March 31, 2013

	2013	2012
	$	$
Operating transactions		
Annual surplus	-	-
Less: items not affecting cash		
Amortization of tangible capital assets	**740,573**	482,142
Amortization of deferred capital contributions (Note 5)	**(740,573)**	(482,142)
	-	-
Changes in non-cash operating items		
Decrease (increase) in due from LHINs	**259,606**	(111,446)
Decrease (increase) in Harmonized Sales Tax receivable	**131,657**	(252,542)
(Increase) decrease in due from MOHLTC regarding HSP transfer payments	**(16,609,412)**	46,113,780
Increase (decrease) in accounts payable and accrued liabilities	**332,376**	(809,133)
Increase (decrease) in due to HSPs	**16,609,412**	(46,113,780)
Increase (decrease) in due to MOHLTC	**144,519**	(29,540)
Decrease (increase) in prepaid expenses	**46,811**	(23,382)
	914,969	(1,226,043)
Capital transaction		
Acquisition of tangible capital assets	**(901,371)**	(1,657,777)
Financing transaction		
Increase in deferred capital contributions (Note 5)	**901,371**	1,657,777
Net change in cash	**914,969**	(1,226,043)
Cash, beginning of year	**392,175**	1,618,218
Cash, end of year	**1,307,144**	392,175

Toronto Central Local Health Integration Network

Notes to the financial statements
March 31, 2013

1. Description of business

The Toronto Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Toronto Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the City of Toronto. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("MLPA"). These financial statements reflect the terms of the MLPA related to this funding.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2013.

The LHIN financial statements do not include any MOHLTC managed programs.

The LHIN is also funded for the Diabetes Regional Coordination Centre program in accordance with the Ministry-LHIN Performance Agreement. The operational mandate, functions and funding for delivery of the RCC Program are being transferred to the LHIN in the 2012/13 fiscal year.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets and losses in the value of assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are initially recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year.

Segmented financial reporting

The financial statements of the LHIN include the accounts of the LHIN Shared Services Office (the "LSSO") and LHIN Collaborative (the "LHINC") which are its divisions. Separate schedules of LSSO and LHINC financial position and financial activities are presented in the attached schedules to the financial statements.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

2. Significant accounting policies (continued)

Adoption of new accounting standards

As at April 1, 2012, the LHIN adopted Public Sector Accounting Handbook *Section PS 1201, "Financial Statement Presentation"*, Section PS 2601 *"Foreign Currency Translation"*, PS 3410 *"Government Transfers"* and Section PS 3450, *"Financial Instruments"*. There was no impact of the adoption of these new standards on the financial statements.

3. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at year end are recorded as a receivable (payable) to (from) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LHINC is responsible for providing advice to all LHINs in the areas of planning integration and community engagement, allocation methodologies, accountability performance and system alignment and co-ordination. Any portion of the LHINC operating costs overpaid (or not paid) by the LHIN at the year-end are recorded as a receivable (payable) to (from) the LHINC. This is all done pursuant to the LHINC Agreement the LHINC has with all the LHINs.

4. Funding repayable to the MOHLTC

In accordance with the MLPA and the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC and eHealth Ontario respectively.

a. The amount repayable to the MOHLTC related to the current activities is made up of the following components:

			2013	2012
	Funding received	Eligible expenses	Excess funding	Excess funding
	$	$	$	$
Transfer payments to HSPs	4,639,988,705	4,639,988,705	-	-
LHIN operations	5,432,951	5,431,373	1,578	1,297
LHINC	670,000	670,000	-	-
LSSO	740,000	740,000	-	-
E-Health	580,000	580,000	-	-
ED Leads	75,000	75,000	-	-
Aboriginal Health Transition Planning	20,000	20,000	-	-
ER/ALC	100,000	100,000	-	-
Critical Care Leads	75,000	75,000	-	-
ALC Resources Matching	483,000	483,000	-	-
Primary Care lead	75,000	75,000	-	-
FLHS	106,000	106,000	-	-
French Planning Entities	421,475	421,475	-	-
Diabetes RCC	21,566	21,566	-	-
	4,648,788,697	4,648,787,119	1,578	1,297

During the year, the LHIN was provided net funding of $421,475 (Note 16) (2012 - $568,713) from the MOHLTC for the French Planning Entities and an amount of $421,475 was flowed directly to "Entité de planification pour les services de santé en français de Toronto Centre".

4. Funding repayable to the MOHLTC (continued)

b. The amount due to the MOHLTC related to current activities and French Planning Entities at March 31 is made up as follows:

	2013	2012
	$	$
Due to MOHLTC, beginning of year	(1,297)	(30,837)
MOHLTC payment	1,297	30,837
Funding repayable to the MOHLTC related to current year activities (Note 4a)	(1,578)	(1,297)
Other funding repayable to the MOHLTC	(147,238)	-
Other funding receivable from the MOHLTC	3,000	-
Due to MOHLTC, end of year	(145,816)	(1,297)

5. Deferred capital contributions

	2013	2012
	$	$
Balance, beginning of year	1,640,726	465,091
Capital contributions received during the year	901,371	1,657,777
Amortization for the year	(740,573)	(482,142)
Balance, end of year	1,801,524	1,640,726

6. Tangible capital assets

			2013	2012
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and fixtures	492,931	269,127	223,804	87,210
Computer equipment	3,638,296	2,803,496	834,800	1,549,993
Leasehold improvements	2,002,454	1,259,534	742,920	3,523
	6,133,681	4,332,157	1,801,524	1,640,726

7. Budget figures

The budget was approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2012. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year, the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $4,639,988,705 is made up of the following:

	$
Initial HSP Funding budget	4,425,789,274
Adjustment due to announcements made during the year	214,199,431
Total HSP Funding	4,639,988,705

The total operating budget, excluding HSP Funding is $7,488,034.

8. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $4,639,988,705 (2012 - $4,506,874,309) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2013 as follows:

	2013	2012
	$	$
Operation of hospitals	**3,571,050,075**	3,470,663,680
Long-term care homes	**254,883,071**	251,359,885
Community care access centre	**215,484,412**	210,048,791
Community support services	**77,900,940**	74,769,503
Assisted living services in supportive housing	**45,521,932**	44,829,549
Community health centres	**85,845,744**	81,843,270
Community mental health addictions program	**107,741,801**	104,420,160
Addictions program	**29,268,187**	26,545,666
Specialty psychiatric hospital	**252,292,543**	242,393,805
	4,639,988,705	4,506,874,309

9. Enabling Technologies

The LHIN received funding of $580,000 (2012 - $600,000) related to the Enabling Technologies project. Enabling Technologies expenses incurred during the year are as follows:

	2013	2012
	$	$
Salaries and benefits	**512,727**	445,889
Professional services	**1,628**	-
Other	**65,645**	154,111
	580,000	600,000

10. Emergency Department ("ED") leads

The LHIN received funding of $75,000 (2012 - $75,000) related to the ED Leads project. ED Leads expenses incurred during the year are as follows:

	2013	2012
	$	$
Salaries and benefits	3,000	3,000
Medical professional services	72,000	72,000
	75,000	75,000

11. Aboriginal Health Transition Planning

The LHIN received funding of $20,000 (2012 - $27,500) related to the Aboriginal Health Transition Planning Project. Aboriginal Health Transition Planning expenses incurred during the year are as follows:

	2013	2012
	$	$
Salaries and benefits	19,191	18,459
Other	809	9,041
	20,000	27,500

12. Emergency Room and Alternate Level of Care (ER/ALC)

During the year, the LHIN was provided funding of $100,000 (2012 - $100,000) from the MOHLTC for the ER/ALC program. ER/ALC expenses incurred during the year are as follows:

	2013	2012
	$	$
Salaries and benefits	95,387	100,000
Other	4,613	-
	100,000	100,000

13. Critical Care (CC) leads

During the year, the LHIN received funding of $ 75,000 (2012 - $75,000) related to the Critical Care Leads project. CC Leads expenses incurred during the year are as follows:

	2013	2012
	$	$
Salaries and benefits	-	1,269
Medical professional services	75,000	72,000
Other	-	1,731
	75,000	75,000

14. Resources Matching Referrals Leads (RMR)

During the year, the LHIN was provided funding of $483,000 (2012 - $387,000) from the MOHLTC for the RMR project. RMR expenses incurred during the year are as follows:

	2013	2012
	$	$
Salaries and benefits	**430,921**	330,717
Other	**52,079**	56,283
	483,000	387,000

15. French Language Health Services (FLHS)

During the year, the LHIN was provided funding of $106,000 (2012 - $106,000) from the MOHLTC for the French Language Health Services program. FLHS expenses incurred during the year are as follows:

	2013	2012
	$	$
Salaries and benefits	**87,952**	85,105
Translation services	**16,181**	17,461
Other	**1,867**	3,434
	106,000	106,000

16. French Planning Entities

During the year, the LHIN was provided with net funding of $421,475 (2012 - $568,713) from the MOHLTC for the French Planning Entities and $421,475 was flowed directly to "Entité de planification pour les services de santé en français de Toronto Centre".

	2013	2012
	$	$
Total Funding received	**568,713**	568,713
Total Funding transferred	**(421,475)**	(568,713)
Prior years funding repayable to the MOHLTC	**(147,238)**	-
	-	-

17. Primary Care Lead

During the year, the LHIN received new funding of $75,000 (2012 - $21,875) from the MOHLTC for the Primary Care Lead program. The expenses incurred during the year are as follows:

	2013	2012
	$	$
Salaries and benefits	**3,611**	6,670
Computer charges	**-**	4,788
Professional services	**407**	-
Medical professional services	**53,958**	6,250
Other	**17,024**	4,167
	75,000	21,875

18. Diabetes Regional Coordination Centre

During the year, the LHIN received new funding of $284,217 from the MOHLTC for the Diabetes Regional Coordination Centre of which $262,651 was used to acquire tangible capital assets and therefore has been recorded as deferred capital contributions (Note 5). The remainder represents operating expenses $21,566 and were incurred during the year as follows:

	2013
	$
Salaries and benefits	10,083
Other	11,483
Total Operating expenses	21,566

19. General and administrative expenses

The Statement of Financial Activities presents the expenses by function; the following classifies general and administrative expenses by object:

	2013	2012
	$	$
Salaries and benefits	4,173,053	3,969,929
Occupancy	302,545	236,159
Amortization	144,518	142,264
Shared services	406,652	539,499
LHINC	87,861	26,971
Consulting services	19,409	56,726
Translation services	43,445	15,257
Professional services	15,675	12,819
Supplies	10,889	78,409
Computer expenses	13,878	330,366
Governance	34,762	48,356
Mail, courier and telecommunications	38,708	42,911
Other	139,978	200,686
	5,431,373	5,700,352

The following lists the Board Chair and Directors per diem costs as well as their travel and expenses which are included in governance expense in the general and administrative expenses above.

	2013		2012
	Budget	Actual	Actual
	$	$	$
Board Chair per diem cost	34,364	11,550	22,050
Directors per diem cost	84,681	23,000	25,825
Board travel and expenses	15,955	212	481
	135,000	34,762	48,356

20. LHIN Shared Services Office

The following presents the financial position and financial activities, by object, of the LHIN Shared Services Office (LSSO) for the year:

LHIN Shared Services Office
Statement of financial position
as at March 31, 2013

	2013	2012
	$	$
Financial assets		
Cash	**502,439**	(178,472)
Due from LHINs	**38,230**	301,836
Due from TC LHIN*	**56,897**	55,967
Due to LHINC*	**-**	4,270
Harmonized Sales Tax receivable	**295,284**	364,894
	892,850	548,495
Liabilities		
Accounts payable and accrued liabilities	**952,305**	624,214
Deferred capital contributions	**890,323**	1,356,201
	1,842,628	1,980,415
Net debt	**(949,778)**	(1,431,920)
Non-financial assets		
Prepaid expenses	**59,455**	75,719
Tangible capital assets	**890,323**	1,356,201
	949,778	1,431,920
Accumulated surplus	**-**	-

* Amounts due to TC LHIN and LHINC are eliminated upon combination.

20. **LHIN Shared Services Office (continued)**

LHIN Shared Services Office
Statement of financial activities
year ended March 31, 2013

	Budget	2013 Actual	2012 Actual
	$	$	$
Revenue			
Amounts recovered/recoverable from the LHINs	4,781,276	5,239,912	5,408,885
MOHLTC funding	700,000	740,000	-
Amortization of deferred capital contributions	-	596,055	339,879
	5,481,276	6,575,967	5,748,764
Expenses**			
Salaries		1,538,204	1,727,135
Benefits		145,021	210,956
Supplies		23,651	23,690
Telecommunications		11,535	17,717
Recruitment and staff development		3,773	16,853
Computer expense		677,680	944,843
Consulting fees		4,025	173,494
Professional services		23,500	21,050
Meeting expenses		3,925	7,479
Amortization		596,055	339,879
Occupancy		161,306	160,499
Other		14,722	38,582
Outsourcing services		3,372,570	2,066,587
Total common LHIN services expenses	5,481,276	6,575,967	5,748,764
Less: inter-entity transactions eliminated on combination***		(481,735)	(652,492)
	-	6,094,232	5,096,272

** Included in total expenses above are $816,777 related to legal expenses, of which $570,366 are MOHLTC salaries and benefits expenses.

*** Included in total expenses above are $481,735 (2012 - $652,492) related to inter-entity transactions and are eliminated upon combination.

21. LHIN Collaborative

The following presents the financial position and financial activities, by object, of the LHIN Collaborative (LHINC) for the year:

LHIN Collaborative
Statement of financial position
as at March 31, 2013

	2013	2012
	$	$
Financial assets		
Cash	**(20,975)**	151,157
Due from TC LHIN*	**109,655**	-
Harmonized Sales Tax receivable	**44,234**	1,006
	132,914	152,163
Liabilities		
Accounts payable and accrued liabilities	**133,910**	95,136
Due to TC LHIN*	**-**	65,668
Deferred capital contributions	**261,853**	-
	395,763	160,804
Net debt	**(262,849)**	(8,641)
Non-financial assets		
Prepaid expenses	**996**	8,641
Tangible capital assets	**261,853**	-
	262,849	8,641
Accumulated surplus	**-**	-

* Amounts due from the LSSO and due to TC LHIN are eliminated upon combination.

21. LHIN Collaborative (continued)

LHIN Collaborative
Statement of financial activities
year ended March 31, 2013

	Budget	2013 Total Actual	2012 Total Actual
	$	$	$
Revenue			
Amounts recovered/recoverable from the LHINs	617,500	443,508	377,588
MOHLTC funding	636,500	670,000	670,000
	1,254,000	1,113,508	1,047,588
Expenses**			
Salaries		722,427	637,932
Benefits		149,184	147,345
Supplies		8,867	9,069
Telecommunications		2,125	21,136
Recruitment and staff development		3,794	3,521
Computer expense		6,442	10,058
Consulting fees		72,436	30,370
Meeting expenses		2,452	425
Occupancy		95,434	94,094
Other		2,847	13,639
Shared services		47,500	80,000
	1,254,000	1,113,508	1,047,588
Less: inter-entity transactions eliminated on combination		(87,861)	(23,030)
	-	1,025,647	1,024,558

** Included in total expenses above are $87,861 (2012 - $23,030) in inter-entity transactions that are eliminated upon combination.

22. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 64 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2013 was $463,986 (2012 - $438,200) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2012. At that time, the plan was fully funded.

23. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the Financial Administration Act.

24. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due over the next five fiscal years are as follows:

	$
2014	714,074
2015	864,080
2016	439,143
2017	-
2018	-

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2014 and 2015. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

Toronto Central Local Health Integration Network

Combined statement of financial position and financial activities by division - Schedule 1
as at March 31, 2013

	2013	2012	2013	2012	2013	2012	2013	2012
	Toronto Central		Shared Services Office		Collaborative		Total	Total
	$	$	$	$	$	$	$	$
Financial assets								
Cash	825,680	419,490	502,439	(178,472)	(20,975)	151,157	1,307,144	392,175
Due from LSSO/LHINC/TC LHIN*	-	61,398	56,897	60,237	109,655	-	166,552	121,635
Due from Local Health Integration Networks ("LHINs")	4,000	-	38,230	301,836	-	-	42,230	301,836
Due from MOHLTC regarding HSP transfer payments	30,147,046	13,537,634	-	-	-	-	30,147,046	13,537,634
Harmonized Sales Tax receivable	103,448	208,723	295,284	364,894	44,234	1,006	442,966	574,623
	31,080,174	14,227,245	892,850	548,495	132,914	152,163	32,105,938	14,927,903
Liabilities								
Accounts payable and accrued liabilities	629,376	663,865	952,305	624,214	133,910	95,136	1,715,591	1,383,215
Due to LSSO/LHINC/TC LHIN*	166,552	55,967	-	-	-	65,668	166,552	121,635
Due to HSPs	30,147,046	13,537,634	-	-	-	-	30,147,046	13,537,634
Deferred capital contributions	649,348	284,525	890,323	1,356,201	261,853	-	1,801,524	1,640,726
Due to Ministry of Health and Long-Term Care ("MOHLTC")	145,816	1,297	-	-	-	-	145,816	1,297
	31,738,138	14,543,288	1,842,628	1,980,415	395,763	160,804	33,976,529	16,684,507
Net debt	(657,964)	(316,043)	(949,778)	(1,431,920)	(262,849)	(8,641)	(1,870,591)	(1,756,604)
Non-financial assets								
Prepaid expenses	8,616	31,518	59,455	75,719	996	8,641	69,067	115,878
Tangible capital assets	649,348	284,525	890,323	1,356,201	261,853	-	1,801,524	1,640,726
	657,964	316,043	949,778	1,431,920	262,849	8,641	1,870,591	1,756,604
Accumulated surplus	-	-	-	-	-	-	-	-

* Amounts due from/to the LHIN Shared Services Office, due from/to the LHINC and due from/to TC LHIN are eliminated upon combination.

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central Local Health Integration Network

Combined statement of financial position and financial activities by division - Schedule I (continued)
year ended March 31, 2013

	2013		2012	2013		2012	2013		2012	2013	2012
	Toronto Central Operations			Shared Services Office			Collaborative				
	Budget	Actual	Actual	Budget	Actual	Actual	Budget	Actual	Actual	Total	Total
	$	$	$	$	$	$	$	$	$	$	$
Revenue											
Amounts recovered/recoverable from the LHINs	-	-	-	4,781,284	5,239,912	5,408,885	636,500	443,508	377,588	5,683,420	5,786,473
MOHLTC funding	5,535,121	5,288,433	5,559,386	700,000	740,000	-	617,500	670,000	670,000	6,698,433	6,229,386
HSP transfer payments (Note 8)	4,425,789,274	4,639,988,705	4,506,874,309	-	-	-	-	-	-	4,639,988,705	4,506,874,309
Enabling Technologies funding (Note 9)	510,000	580,000	600,000	-	-	-	-	-	-	580,000	600,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Aboriginal Health Transition Planning (Note 11)	20,000	20,000	27,500	-	-	-	-	-	-	20,000	27,500
Emergency Room and Alternate Level of Care (ER/ALC) (Note 12)	100,000	100,000	100,000	-	-	-	-	-	-	100,000	100,000
Critical Care ("CC") Lead (Note 13)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Resources Matching Referrals (Note 14)	423,200	483,000	387,000	-	-	-	-	-	-	483,000	387,000
French Language Health Services (Note 15)	106,000	106,000	106,000	-	-	-	-	-	-	106,000	106,000
French Planning Entities (Note 16)	568,713	421,475	568,713	-	-	-	-	-	-	421,475	568,713
Primary Care Lead (Note 17)	75,000	75,000	21,875	-	-	-	-	-	-	75,000	21,875
Behaviour Support Ontario	-	-	57,000	-	-	-	-	-	-	-	57,000
Diabetes Regional Coordination Centre (Note 18)	-	21,566	-	-	-	-	-	-	-	21,566	-
Amortization of deferred capital contributions (Note 5)	-	144,518	142,263	-	596,055	339,879	-	-	-	740,573	482,142
	4,433,277,308	4,647,378,697	4,514,594,046	5,481,284	6,575,967	5,748,764	1,254,000	1,113,508	1,047,588	4,655,068,172	4,521,390,398
Funding surplus repayable to the MOHLTC related to operations (Note 4(a))	-	(1,578)	(1,297)	-	-	-	-	-	-	(1,578)	(1,297)
	4,433,277,308	4,647,377,119	4,514,592,749	5,481,284	6,575,967	5,748,764	1,254,000	1,113,508	1,047,588	4,655,066,594	4,521,389,101
Expenses											
General and administrative (Note 19)	5,535,121	5,431,373	5,700,352	-	-	-	-	-	-	5,431,373	5,700,352
Common LHIN Services* (Note 20)	-	-	-	5,481,284	6,575,967	5,748,764	-	-	-	6,575,967	5,748,764
LHIN Collaborative** (Note 21)	-	-	-	-	-	-	1,254,000	1,113,508	1,047,588	1,113,508	1,047,588
Transfer payments to HSPs (Note 8)	4,425,789,274	4,639,988,705	4,506,874,309	-	-	-	-	-	-	4,639,988,705	4,506,874,309
Enabling Technologies (Note 9)	510,000	580,000	600,000	-	-	-	-	-	-	580,000	600,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Aboriginal Health Transition Planning (Note 11)	20,000	20,000	27,500	-	-	-	-	-	-	20,000	27,500
Emergency Room and Alternate Level of Care (ER/ALC) (Note 12)	100,000	100,000	100,000	-	-	-	-	-	-	100,000	100,000
Critical Care ("CC") Lead (Note 13)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Resources Matching Referrals (Note 14)	423,200	483,000	387,000	-	-	-	-	-	-	483,000	387,000
French Language Health Services (Note 15)	106,000	106,000	106,000	-	-	-	-	-	-	106,000	106,000
French Planning Entities (Note 16)	568,713	421,475	568,713	-	-	-	-	-	-	421,475	568,713
Primary Care Lead (Note 17)	75,000	75,000	21,875	-	-	-	-	-	-	75,000	21,875
Behaviour Support Ontario	-	-	57,000	-	-	-	-	-	-	-	57,000
Diabetes Regional Coordination Centre (Note 18)	-	21,566	-	-	-	-	-	-	-	21,566	-
	4,433,277,308	4,647,377,119	4,514,592,749	5,481,284	6,575,967	5,748,764	1,254,000	1,113,508	1,047,588	4,655,066,594	4,521,389,101
Annual surplus and accumulated surplus, end of year	-	-	-	-	-	-	-	-	-	-	-

* These amounts will be adjusted by $481,735 for Toronto Central LHIN transactions. These numbers reflect LSSO operations on behalf of all 14 LHINs (Note 20).
** These amounts will be adjusted by $87,861 for Toronto Central LHIN transactions. These numbers reflect LHINC operations on behalf of all 14 LHINs (Note 21).

The accompanying notes to the financial statements are an integral part of these financial statements.

Toronto Central **LHIN**

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